Reset Form

STATEMENT OF MEDICAL CONDITION FOR THE FOOD STAMP AND TEMPORARY ASSISTANCE FOR NEEDY FAMILIES PROGRAMS

State Form 31662 (R9 / 4-06) / FI 0006C

All information collected on this form will be treated as confidential according to 470 IAC 1-3-1 or 470 IAC 6-1-1.

Date (*month, day, year*)	Case / cat. / seq. number
Name of assistance group payee	
Name of caseworker	

TO: (*physician/psychologist*)	**RE:** (*name of patient*)
Address (*number and street*)	Address (*number and street*)
City, state, and ZIP code	City, state, and ZIP code

PATIENT AUTHORIZATION STATEMENT

I, _____ , hereby request and authorize that information requested about my mental and/or physical condition be disclosed to the _____ County Office of Family and Children in order to determine:

- ☐ The extent to which I am able to participate in employment and / or training activities.
- ☐ Whether my family is eligible for Temporary Assistance for Needy Families (TANF) due to my incapacity.

This authorization is valid for 60 days from the date signed and subject to revocation upon my request prior to that expiration.

Signature of patient	Date (*month, day, year*)

PHYSICIAN / PSYCHOLOGICAL INFORMATION

The information provided will be used to determine whether and to what extent the individual will be able to participate in activities designed to assist him/her in achieving employment to the fullest extent possible. Documentation of the individual's physical and/or mental strengths and limitations is needed as well as an explanation (*if the individual is completely unable to work*) of how and why the condition prevents employment. Partial or marginal disability may indicate only that certain jobs or activities may not be suitable for the individual, but others would be within his/her mental and physical ability to perform.

(*Please check one*)

- ☐ 1. The individual has no significant physical or mental limitations and could engage in a gainful occupation.
- ☐ 2. The individual is totally unable to work.
  - ☐ This is a permanent condition OR
  - ☐ This condition is temporary until _____ (*month, day, year).*
- ☐ 3. The individual has the following physical or mental limitations which should be considered in determining the type and scope of employment or training activities to which this individual is assigned. _____

(*If #3 is marked, please complete the General Strengths and Capabilities Section and Medical / Psychological Information.*)

GENERAL STRENGTHS AND CAPABILITIES

Please check which of these activities the patient is capable of performing and indicate any limitations:

ACTIVITY	LIMITATIONS	ACTIVITY	LIMITATIONS
☐ Sitting		☐ Pushing/Pulling	
☐ Standing		☐ Bending	
☐ Walking		☐ Other	
☐ Lifting		☐ Other	
☐ Grasping		☐ Other	

If the patient's condition requires limited work hours, please indicate how many hours may be worked per week _____

MEDICAL/PSYCHOLOGICAL INFORMATION

	DIAGNOSIS	ESTIMATED DURATION	PROGNOSIS WITH TREATMENT
A. PRIMARY			
B. PRIMARY			
C. SECONDARY			
D. SECONDARY			

MENTAL CAPABILITIES: *Please complete this section if there is a diagnosis of learning/reading disability or* psychiatric disorder.

Full scale I.Q. or estimated mental age	Learning disability or psychiatric disorder

Please add any additional information which you believe will assist us in helping your patient achieve employment to the fullest extent possible. Back of form may be used.

Note to physician or psychologist: by court order and federal regulation, this information is available to the patient or his/her legal representative upon request.

Signature of physician/psychologist	Date (*month, day, year*)

Please return the completed form to: